

Implementation of the *FISH!* Philosophy in Primary Care:

A change in the culture of healthcare delivery

Leslie Ann Arledge

East Carolina University

## Abstract

**Background:** Public Health Departments often serve a disenfranchised patient population.

While practitioners are committed to providing exceptional care to vulnerable populations, lack of resources and governmental bureaucracy often result in provider and staff fatigue that can translate to high attrition rates. Supporting staff may not share the institutional vision of being viewed as a leading resource for community healthcare services.

**Problem:** The clinical atmosphere was dull and bleak. It lacked, light, color, and energy. Staff morale was generally low and patient satisfaction scores were suboptimal. The purpose of this project was to transform the culture of healthcare delivery. The clinical question was: Will a new philosophy of conducting daily work enhance staff fulfillment and improve retention? Can noticeable improvements be realized in patient satisfaction scores through enhancements in organizational culture?

**Methodology:** The *FISH!* Philosophy was implemented to structure cultural improvement. Four key aspects of this philosophy are: 1.) Play – encourage creativity and enjoyment at work; 2.) Make their day – an effort to enhance the lives of patients and colleagues regularly; 3.) Be there – embrace the moment and be fully engaged; 4.) Choose your attitude – there is a choice in the way we approach our daily work and lives. Energetic employees translate to satisfied patients and organizational success.

**Evaluation:** A comparison of pre and post employee surveys were utilized to appraise the strategic efficacy of the *FISH!* Philosophy. These demonstrated an overall improvement in the final evaluation of enjoyment of the work culture, feeling appreciated, and a shift in work perception to determine success of the quality improvement initiative. Staff retention further illustrated improvement. The current tool utilized to measure patient satisfaction was deployed to

assess change. Enhancements were noted in the patient satisfaction survey for the quarter during this quality improvement initiative compared to the previous two reporting years for the same quarter and year-end results.

*Keywords:* organizational culture, employee satisfaction, job satisfaction, *FISH!*

Philosophy, primary care, public health

## Acknowledgements

This scholarly project for a doctoral program was inspired by Dr. Janet Tillman in her leadership course. She later became my Committee Chair and continued the mentorship throughout the journey of conceptualizing and implementing the *FISH!* Philosophy in my work setting. Dr. Susan Layne Albert, Medical Director at Wilkes County Health Department is an inspiration to me and other members of the clinic staff. Her commitment to my vision for improving the work culture and team cohesion was essential in achieving the required buy-in from other staff members. Ann Absher, Health Director at the Wilkes County Health Department supported my academic and professional goals throughout this process. The Outreach Staff, especially Jared Belk, were assistive in distributing surveys, collecting data, and protecting patient and employee privacy. Kerry Sewell is the phenomenal librarian from ECU. She was assistive in finding and collecting the literature necessary for this project and always readily available.

I am a member of a self-named group: “The Three Musketeers.” The only three full-time post-masters’ students in the doctoral program that joined by chance and formed a bond and friendship that extended beyond the boundaries of this program. Alex Hodges and Jodi Amador have contributed to my success. Lastly, my wonderful husband Robert Arledge, has been my champion, sounding board, and coach as I have endured this journey. His brilliant mind, enthusiasm, and participation in many of the team building activities enabled my success in creating this project and made the process fun during the implementation phase.

## **Project Approval**

East Carolina University Doctor of Nursing Practice

Scholarly Practicum Project Approval

Dr. Janet Tillman DNP, RN, FNP-BC

## **Table of Contents**

### Chapter 1: Page 8

- Introduction
- Problem Statement and Rationale
- Process and Outcome Objectives
- Definition of Terms
- Theoretical Framework

### Chapter 2: Page 18

- Review of the Relevant Literature
- Keywords and Search Terms
- Literature Synthesis

### Chapter 3: Page 22

- Methodology
- Marketing and Financial Plan
- Evaluation Strategies
- IRB Process and Approval

### Chapter 4: Page 29

- Results

### Chapter 5: Page 37

- Discussion
- Sustaining Change

References: Pages: 42-44

Appendices

- Appendix A: Patient Satisfaction Survey: Page 45
- Appendix B: Provider and Employee Satisfaction Survey: Page 46-47
- Appendix C: E-mail Authorization for Tool Utilization: Page 48
- Appendix D: Institutional Authorization for Project: Page 49
- Appendix E: ORIC Exemption Letter: Page 50
- Scholarly Practicum Timeline: Pages: 51-52

## Chapter 1

### A Quality Improvement Initiative for an Organizational Culture

How do you make people *want* to come to work? The body of evidence demonstrated that organizational performance and employee satisfaction are strongly correlated to the culture of the organization (Dugan et al., 2011; Brazil et al., 2010; Tsai, 2011). A study by Brazil, Wakefield, Cloutier, Tennen and Hall (2010) indicated that organizational culture is an essential consideration in healthcare as it influences the quality of healthcare delivery and patient outcomes. Roth and Markova (2012) illustrated that successful teams demonstrate a synergistic approach to patient care delivery that creates a thriving organization. This includes the promotion of satisfying and enjoyable work environments where trust, diversity, communication, and joy enhance employee satisfaction and reduce staff turnover. This translates to office personnel, nurses, and providers who are more likely to deliver exceptional patient care and achieve desirable outcomes (Roth & Markova, 2012).

This quality improvement initiative examined the utilization of the *FISH!* Philosophy in transforming the organizational culture in a primary care setting. The premise in this philosophy is that deliberate intentions to infuse energy, excitement, passion, and fun into daily work activities create an enjoyable atmosphere that promotes a successful organization (Lundin, Paul & Christensen, 2000). Lundin, Paul and Christensen (2000) identified four key concepts that embody the *FISH!* Philosophy: Play; Make their day; Be there; and Choose your attitude.

Each of these four key concepts were employed to transform a disjointed organizational culture in an effort to heighten employee morale and job satisfaction. Resistance to change and varying rates of acceptance were anticipated barriers in this quality improvement (QI) initiative. Lewin's Change theory was assistive in guiding staff through the change process. The



anticipated result was improved employee satisfaction, enhanced employee retention, and increased patient satisfaction.

### **Problem Statement and Rationale**

There is a multitude of challenges encountered in healthcare delivery within primary care. Managing patients with chronic disease and a myriad of psychosocial barriers can be emotionally depleting, even for the most enthusiastic members of the healthcare team (Brazil, Wakefield, Cloutier, Tennen & Hall, 2010). A study by Harper, Castrucci, Bharthapudi and Sellers (2015), demonstrated that a legion of challenges exist in delivering primary care in a public health setting. Among these is the recruitment and retention of qualified staff. Approximately 91% of public health agencies have experienced attrition and 42% of the current workforce has considered leaving their current employment within the next year (Harper, Castrucci, Bharthapudi & Sellers, 2015). According to Liss-Levinson, Bharthapudi, Leider, and Sellers (2015), employee engagement, organizational support, and job satisfaction are all significant predictors for desiring to remain in public health.

The project site was a public health department located in rural western North Carolina that has an integrated primary care clinic. County, state, and federal funding, with the additional financial support from grants, provide access to healthcare for child and adult health, sexually transmitted disease, family planning, and breast cancer and cervical cancer prevention (BCCCP). The clinic is situated in a 50-year-old structure with block concrete walls. Not a single window exists, the lighting was poor, and the paint color is a drab shade of beige. The appearance and atmosphere is sterile, with the lackluster semblance of an old construction in desperate need of renovation. Comments concerning this depressing environment had been expressed in statements from current staff as well as as interns, nursing, phlebotomy, nurse practitioner, and physician

assistant students. Many of the supporting staff members had lengthy tenures that ranged from eight to 21 years of service. These members often demonstrated the pervasive attitude of, “it’s the health department, what do you expect?” Staff were often resistant to change and further demonstrated animosity towards new members of the team. As a result, staff retention had been poor and twelve terminations or resignations for the clinic employees transpired in the 18 months preceding this quality improvement initiative.

Supporting departments for customer service did not behave as an integrated team, and fault was routinely identified in others. Employee comments identified lack of coordination as an area of concern. While patient satisfaction surveys were generally encouraging, only ten were completed in the year previous to this quality improvement initiative. When taken into context, ten surveys were captured for the child and adult health clinics that had 7,033 patient encounters. This resulted in a rating of 78% among English-speaking patients for the perception of the clinical processes and overall satisfaction in 2015. Limited efforts to capture this valuable feedback demonstrated curbed levels of commitment to evaluate patient satisfaction. Clinical quality improvement initiatives focused on processes and did not examine areas to enhance employee performance or identify potential for improvement. With reimbursement trending towards patient satisfaction and “fee for service,” this required more in-depth perusal and active efforts focused for the advancement of this primary care clinic.

**Leadership involvement and limitations.** The majority of programs are supported through county, state, and federal funding. The adult health clinic, which targets serving the primary healthcare needs of a vulnerable population, is dependent upon county and grant funding for financial support. The Duke Endowment Grant is currently the largest source of funding for adult chronic disease management, but insufficient to provide community needs long-term. This

rural health department is currently seeking Patient Centered Medical Home (PCMH) accreditation. In addition to this, grant funding to become a Federally Qualified Health Center (FQHC) is underway. According to the Centers for Medicare and Medicaid Services (CMS, 2016), FQHC services are defined as physician services; supplementary nurse practitioner, physician assistant, and social work benefits; and outpatient medical nutritional therapy and diabetic counseling. These all depict aims toward primary preventative healthcare services (CMS, 2016). The acquisition of this grant funding is essential for longevity of the adult health clinic. Without it, the current primary care clinic is unsustainable. However, this is a vital need for the community.

Members of the leadership team are inclined to focus on finances, pursuing accreditation, and grant funding opportunities to support the primary care clinic. This has resulted in a staff perception for lack of involvement in the daily operations and ongoing needs of daily clinic operations. Previous to this quality improvement initiative, the majority of management support team members displayed a seldom presence within the clinic. This created a communal impression of disengagement and diminished support for the team members that were the most involved members in patient care. While the leadership mission has been to yield additional financial funding for continued clinical pursuits and enhancement of the clinic and health of the community, these goals were poorly communicated. This was reflected in an employee satisfaction comment that included: “Pets get big salaries and those of us on the low end of the salary scale are being threatened with their jobs. If the grant is received, staff will be broken up and this will only decrease morale even more.”

A “we versus they” perception among team members is prevalent and a shared concern in the commentary for survey results. This was expanded on with this co-worker explicitly

declaring that there “is a desperate need” for interdepartmental cooperation, respect, and team building. The additional statements from this individual included the “trickle down effect” from leadership that has a powerful effect on the morale of the organization.

### **Purpose Statement**

In a primary care environment that serves a disenfranchised population with limited or lacking resources, supportive, nursing, and provider staff may become disjointed, dissatisfied with the work environment, and emotionally depleted. This results in attrition, which is costly in terms of recruitment and training, but also has the potential to translate to poorer patient care and outcomes (Liss-Levinson et al., 2015). The purpose of this project was to create and preserve an excellent patient care team. Furthermore, aggregation of the different departments that comprised each layer of the patient experience into a cohesive and cooperative unit was the aim. There was further cause to build on this purpose as the project site was seeking PCMH accreditation and FQHC funding to continue the endeavors of supporting the community. Planned quality improvement strategies are necessary for maintenance of Joint Commission Accreditation. This project will meet that aim. Additionally, management targeted a 90% patient and employee satisfaction rate to achieve FQHC grant capitalization to expand primary care within this rural health department.

### **Process and Outcome Objectives**

John Christensen’s father was the documentary filmmaker that founded ChartHouse Learning more than fifty years ago (“Searching for a model,” 2015). This institution had historically created motivational videos to embolden the human spirit and developed training tools and programs to promote organizational success. As a documentarian that was inspired by the same vision, John Christensen was the founder of the *FISH!* Philosophy. An accidental

encounter at the Pike Place Fish Market in Seattle, Washington in 1998 encouraged a sense of excitement for an innovative method of conducting business (Searching for a model,” 2015). Through intensive observations of the fishmongers that exhibited energy, excitement, and passion for their work, Christensen developed a strategy for organizational improvement.

The *FISH!* Philosophy has been utilized in thousands of organizations around the globe since inception (“Searching for a model,” 2015). In a discussion that shared the successful implementation of the *FISH!* Philosophy in an acute care setting, Rees (2004) highlighted that this fish market is renowned for a fun atmosphere and excellent customer service. An exceptional experience, promoting teamwork and interdisciplinary cohesion, and conjuring excitement and passion are the cornerstones of this philosophy (Lundin, Paul & Christensen, 2000).

In a study that evaluated the incorporation of fun from the *FISH!* Philosophy concept in healthcare settings, Peluchette and Karl (2005) examined the activities that were rated among employees as most enjoyable. These included theme days, contests, and food related events. They cited four hospitals that have touted the success of this framework. Rees (2004) discussed the implementation of *FISH!* culture in one of these settings. He noted that the hospital VP and COO’s motto was “If you have happy employees, you have happy patients.” In another hospital environment with successful implementation on a medical unit, Lyall (2007) shared that interest was received from other departments and there were intentions to spread the culture. White and Whitman (2006) evaluated the utilization of the *FISH!* Philosophy in a home health setting in a successfully blending of two separate teams into a cohesive unit.

## Definition of Terms

**Play.** Contrary to initial perceptions about “play” at work, this concept is not about “goofing off” or ignoring the serious implications involved in healthcare delivery. It is about conducting work with a lighthearted and spontaneous approach that gets the job done in a way that is satisfying and enjoyable for both staff and patients (Lundin, Paul & Christensen, 2000). In a discussion of the implementation of the *FISH!* Philosophy in an acute care setting, Lyall (2007) highlighted that “play” is not about throwing fish, it is about throwing one’s self into daily performance. According to Peluchette and Karl (2005), permeating the work culture with humor and camaraderie encourages motivation, decreases stress, and enhances employee and customer satisfaction. Launching teambuilding exercises, instituting weekly and monthly events, and infusing laughter everyday were expected to bring “play” into the daily work culture (Lundin, Paul & Christensen, 2000).

**Make Their Day.** As illustrated by Lundin, Paul and Christensen (2000), the natural human desire is to feel appreciated and valued. “Making their Day” is an intentional effort to make another individual’s day positive. This is a willful expression of appreciation, value, and gratitude (Lundin, Paul & Christensen, 2000). As one of the key cornerstones of the *FISH!* Philosophy, this concept is applicable to interactions with both team members and patients. Accomplishing an organizational culture that openly recognized each team member’s gifts and talents was the expected outcome. Furthermore, the goal was to deliberately acknowledge the inherent value of each patient.

**Be There.** Closely related to “Making their Day,” “Be There” is a key concept that promotes purposeful engagement. At least 75% of our lives are invested in work-related activities (Lundin, Paul, & Christensen, 2000). Coworkers are a familial extension; they are our

“work family.” Yet these relationships are often neglected. An expansion of this relationship is demonstrated through patient encounters. Delivering quality, effective, and personalized healthcare incorporates personal and intimate details about the lives of individuals. “Being there” is about building connections through trust and mutual respect, letting others know they are appreciated, and investing fully in the moment (Lundin, Paul & Christensen, 2000). As White and Whitman (2008) noted, this is a transformation from working together to “coming together” through the involvement of the healthcare team and patient participation. Intentional coaching efforts, for both patients and staff, were expected to create cohesion and build meaningful relationships.

**Choose Your Attitude.** This simple to understand concept may be the most difficult to demonstrate consistently, especially in a challenging work environment. There is a choice in the kind of day we experience and choosing the right attitude is a decision we have the power to make (Lundin, Paul & Christensen, 2000). As the *FISH!* Philosophy illustrates “there is always a choice in the *way* you do your work, even if there is no choice in the work you do” (Lundin, Paul, & Christensen, 2000). Guiding the healthcare team to greet every day and each encounter with joy was anticipated to transform the organizational culture (Roth & Markova, 2012). The assumption was that improvements would be noticeable in staff retention, employee enjoyment, and patient satisfaction.

### **Theoretical Framework**

Kurt Lewin is considered the father of social psychology (Shirey, 2013). As Butts and Rich (2015) noted, his pioneering work focused on analyzing behavioral sciences, group dynamics, and organizational change. While initially developed in 1951, Deckelman et al. (2010) illustrated that Lewin’s Change Theory has been extensively applied to numerous organizational

and nursing change initiatives with successful outcomes for decades. It provided an easy to follow framework for reorganization and a methodology to incorporate the human aspect involved in change processes (Deckelman et al, 2010; Shirey, 2013).

Lewin's Change Theory was appropriate for application of the *FISH!* Philosophy. As an assistive tool in evaluating the people side of change, it afforded recognition of resistance. In an analysis of employee resistance to change, Oreg & Sverdlik (2011) characterized employee reactions to change as a contrast between the conflicting demands of personal desire and professional requirements. As a bipolar problem, the competing needs may create ambivalence. (Oreg & Sverdlik, 2011). This is a natural dilemma in change initiatives and a pitfall that was necessarily identified and addressed for a successful outcome of this QI initiative. Those who perceived forced change, lack of independence and loss, were anticipated to thwart innovation and advancement (Decklman et al, 2010).

The Force Field Analysis (FFA) established a framework for investigation of the driving and conflicting factors that either provoke or inhibit change (Shirey, 2013). As a method that provided a roadmap for examination of the totality and complexity of the people side of change, the FFA granted understanding of behavior for a change initiative (Shirey, 2013). There are three key concepts within Lewin's FFA. First is the driving force that exerts a directional push for change. This is an identification of discrepancies between the current situation and the goal. Second, is the concept of the restraining forces that counter the drive to alter behavior. These may be internal or external forces, but often they are the result of a desire for group conformity. The third concept in Lewin's framework is equilibrium, where the driving and restraining forces exist in balance and no change occurs (Shirey, 2013).



The stages of change within Lewin's theoretical framework are important in understanding the phases of change and recognizing that it is a process, not an event (Butts and Rich, 2015). "Unfreezing" involves the identification of a need for change and the preparation required to mobilize the process (Butts & Rich, 2015). This is the basis of FFA (Shirey, 2013). The second stage involves movement and transition. This was expected to be a collaborative and participative process where each stakeholder contributed and resistance was mitigated. The final stage is "Refreezing," whereby change was integrated and became the new culture. Commitment was essential for preserving sustainability and preventing regression (Decklman, 2010).

## Chapter 2

### Review of the Relevant Literature

The initial literature search was conducted to include information related to the application of the *FISH!* Philosophy in a healthcare setting. No articles were found that addressed the utilization in primary care or in public health. Five articles were identified that addressed incorporation in a healthcare setting. No time limit was imposed as an exhaustive search was warranted when the initial limitation of literature was identified. The remainder of the literature review covered a five-year timeframe to afford the most contemporary information. This review specifically targeted organizational culture and job satisfaction and was conducted with the use of two electronic bibliographic databases, PUBMED and CINAHL. Articles that were specific to primary care were extracted for examination. An additional literature search was an extrapolation of research related to public health. Another literature review was employed to explore publications from the developer of the Provider and Employee Satisfaction Survey that would be utilized in the project. A final search was conducted for examination of self-rated levels of team member morale as this was identified as a barrier in the combined employee and provider satisfaction survey and as an area that warranted further examination. PsychINFO was the database utilized for exploration of literature related to employee morale. All searches were limited to human subjects and the English language (see Table 1).

## Keywords and Search Terms

Table 1		
<i>Keywords and Search</i>		
<u>MESH Terms</u>	<u>Title/Abstract</u>	<u>Additional Keywords</u>
Patient Satisfaction	Patient satisfaction	<i>FISH!</i> Philosophy
Professional-patient relations	Professional-patient relations	Lewin's Change Theory
Organizational culture	or relationships	Catherine Tantau
Job Satisfaction	Organizational culture or	Public Health
	corporate culture	Job Satisfaction
	Job Satisfaction or Work	
	Satisfaction	
	Employee Morale	
<i>Note.</i> Searches were conducted through PubMed and CINAHL.		

## Literature Synthesis

**The *FISH!* Philosophy.** Although there is wide recognition of the beneficial components of the *FISH!* Philosophy in thousands of organizations (Rees, 2004; Lundin, Paul, & Christensen, 2000), there was little literature that addressed the implementation in a healthcare setting. It is possible that a lighthearted approach may be viewed as inappropriate when considering the serious implications of healthcare delivery. Despite this, five articles clearly documented success and sustainability in hospitals and a home health setting. In an examination of evaluating employee attitudes for incorporating fun into the workplace, Peluchette and Karl (2005) noted various perceptions. Success in this regard was aimed at evaluating what the employee desired for their own work environment. As Lyall (2007) indicated, “the brain can be hired; the heart and soul have to be earned” (p. 3). Lyall recounted the successful implementation of the *FISH!* Philosophy in creating a change in culture for behaviors and attitudes. As White and Whitman (2006) noted, success is not derived from following a current trend, but through the consistent blending and cohesion of groups.

**Organizational Culture.** Brazil et al. (2010) depicted a strong correlation between job satisfaction and perceived clinical efficacy, stating there is a wide variant in perceptions and assumptions among group members in a work environment. This created the rationale for examining what provokes or limits high performance through an employee survey. Dugan et al. (2011) highlighted the necessity of identifying the organizational weaknesses for improvement of processes and outcomes. Commitment to quality and teamwork are paramount; these components are especially true for an organization seeking Patient Centered Medical Home (PCMH) accreditation (Dugan et al., 2011). In a study that uncovered a positive correlation between leadership behavior and employee job satisfaction, Tsai (2011) discussed the effects of shared beliefs and values within an organization to create cohesion for the unit. Furthermore, Tong and Wang (2011) explained the work locus of control has a significant impact on employee behavior. This is the internal or personal control one may be afforded to exhibit over his or her own work environment and is critical to a successful cultural change initiative. Anazai, Douglas & Bonner (2014) discussed the findings from their study where a favorable practice environment, collegial atmosphere, supportive environment, and strong nursing administration all improve the work environment. Quality leadership can be the driving force of establishing a thriving organization (Hicks, 2011).

**Public Health.** Recruiting and retaining qualified, empathetic, and skilled members of the healthcare team is a challenge (Liss-Levinson et al., 2015). The governmental bureaucracy that is an integral component of patient care in a public health setting presents a unique challenge (Harper et al., 2015). In a study that examined the predictors for loving and leaving public health, Liss-Levinson et al. (2015) identified that higher overall tenure is predictive of lower rates of employee turnover. Additionally, they identified that staff engagement, organizational support,

and job satisfaction were all significant predictors of desiring to remain in this type of setting.

Organizational support and leaders that can effectively support the team are essential. They have conceivable ability for influence that can translate to higher degrees of job satisfaction (Harper et al., 2015). This premise should necessarily include all leaders in a healthcare team.

### Chapter 3

#### Methodology

The *FISH!* Philosophy was implemented as the method to infuse enthusiasm into healthcare delivery in a public health setting and Lewin's Change Theory was the assistive tool to guide staff through the change process. A slide presentation at a monthly staff meeting was selected as the opportunity to launch the key concepts for this philosophy and introduce staff to the aims of the QI initiative. The initial presentation established a set of standards and instituted the expectation for the support of colleagues in delivering exceptional patient care. There was further intention to motivate and inspire the attendants about the personal and professional gains that can be adopted through enhancement of the work culture. Lewin's Change Theory was utilized as a framework to identify and mitigate barriers through the course of this initiative.

The slide presentation shared the cornerstones of the *FISH!* Philosophy and included suggestions or examples of how each of the four main concepts could be incorporated into the work culture and patient and staff interactions. Sharing personal or witnessed encounters was beneficial in providing experiences and observations where components were in place, though not routinely practiced. This created an opportunity for clarification regarding the project aims and the benefit for each stakeholder. Components of these slides were placed throughout the clinic as a regular reminder and to fortify the project aims. At the closure of the project, the slide presentation was revisited to reinforce the continued aspirations of this QI initiative.

The first exercises targeted the adaptation of a change in the work environment through dialogue. These were implemented by making rounds and engaging in daily team member discussions regarding the personal and professional benefit of an improvement in the work climate. Regular contact with the many clinical, accounts receivable, registration, and scheduling

staff members to reinforce the goals and mission for the health department were initially utilized to reiterate the *FISH!* Philosophy culture. Emphasizing the goal of making alterations for the benefit of each individual became daily conversation. Intentional efforts to hear questions, address concerns, and invoke ideas was critical.

Fridays were previously established as casual dress days, where blue jeans were appropriate. This was determined as the ideal day for *FISH!* themed festivities to build enthusiasm and an opportunity to ingrain the concepts of the culture into the work environment. Breakfast, snacks, and lunches granted brief moments of play, afforded opportunities for appreciation and collaborative engagement, and created occasions for team building. These became anticipated experiences for staff members. Questions regarding planned activities for Friday became routine. Additionally, these moments offered the celebration of our “work family.”

To further examine the employee needs for a work culture improvement, the four main patient contact departments were divided to represent the key cornerstones of the *FISH!* Philosophy. Random assignment of the four interdisciplinary departments comprised the formation of these teams. Employees were asked draw cards to determine which *FISH!* concept to explore, and identify methods to achieve enhancement of the work culture or consider areas where success already existed. A poster contest for each of these four groups with awarded prizes for the winning team encouraged participation. Intentionally pairing group members from different departments to identify strengths, evaluate and collaborate about areas requiring improvement, was anticipated to assist in breaking down existing barriers and improve interdepartmental cohesion. Since culture is socially learned and leadership behavior and support have a strong influence on employee performance, the incorporation of management support in

this process was initially thought to be essential for success (Tsai, 2011). It was later determined that their guidance and encouragement would prove beneficial in achieving many of the project aims, but the actual considerations for improvement should be adopted from those that are the intrinsic partners in patient care.

### **Marketing and Financial Plan**

Marketability for a cultural change and QI initiative is derived through consistent leadership and regular coaching (Tsai, 2011). Implementation of the *FISH!* Philosophy culture was supported through the medical director, health department director, providers, management support, and actualized by the project investigator. Specific and intentional efforts aimed at incorporating all members of this team were paramount requirements to achieve and maintain buy-in. Ongoing discussions with leaders, clinicians, and supporting staff team members were created to build rapport and reinforce the facility's mission and goals. This was accomplished through regular promotion and repetition of each individual's ownership in this public health setting. In a work environment where the status quo was the accepted standard, the challenge was to make employees *want* to change and envision his or her own benefit in altering behavior to improve the organizational culture.

Resistance was an anticipated barrier to successful project implementation. This was derived from a working experience within the clinic and ongoing dialogue with team members. Reiterating the personal gain was effective in overcoming the majority of resistance. It was largely accomplished through intentional efforts at targeting the members of the team that voiced negativity, exhibited poor team spirit, or demonstrated low levels of participation in activities.

Alteration of the physical work environment proved challenging as there are limited funds in public health and structural changes were virtually impossible. The fiscal year closed in



June, and the health department director agreed to seek funding to paint the clinic and install new lighting fixtures as a strategy to remove the dreary perception of the work environment and upgrade the work setting. The new lighting has now been installed. This was completed through the entirety of the health department. The total material cost was \$29,075.30 with an additional labor cost for installation of \$6,125.00. Despite the lack of windows that allow daylight in the clinic and waiting areas, this has improved the overall brightness and enhanced clinical visualization. In addition, a paint color has been selected to diminish the sterile ambiance. This was anticipated to be completed before the end of 2016; however, funds were necessarily allocated to physical repairs and have created a delay. Some providers have personally invested in adorning their own clinic exam rooms with colorful artwork. The medical director is seeking an individual to paint murals on the clinic hallways. Consideration is being given to a high school art group to reduce cost and incorporate community involvement.

Monthly staff meetings and regular staff huddles were already incorporated into practice and provided opportunity for reaffirmation with no cost incurred. The remainder of financial support for meals, activities, and incentives were out of pocket expense for the project investigator. The total cost incurred for these was \$876.93. Although financial support was offered from the health director, departmental funding was considered best allocated to other areas for clinic improvement.

Financial sustainability for this QI initiative will be supported by team members long-term. Staff have agreed to contributing two dollars from each paycheck, for a total of \$24 in annual dues to continue monthly events. Additional costs incurred will be out-of-pocket expenses for individuals willing to bring food or decorations for special events. Health

department funding will sustain the annual picnic and a monthly gift certificate rewarding the employee nominated for excellent team member behaviors.

### **Evaluation Strategies**

Patient satisfaction surveys, especially for the clinic, were underutilized in evaluating the success of healthcare delivery within this public health setting. The current tool is a brief survey that addresses eight key aspects and is offered in both English and Spanish versions (Appendix A). It is a paper-based tool that is distributed at registration or check-out. It is completed at the conclusion of the office visit. As an alternate option for response, clients are able to mail their completed survey. This approach for evaluating patient satisfaction allows anonymity. The data is compiled by the Community Outreach Team who examine departmental satisfaction. These surveys include all major patient points of contact. This includes the patient care clinic, Mobile Expanded School Health unit (MESH), Women Infants and Children (WIC), Diabetes Center, and Outreach. Within the clinic setting, surveys were seldom distributed as it required an additional effort from staff and the necessity was not routinely reinforced. An emphasis on distribution to evaluate clinic standing and assess progress was warranted as a small number of completed surveys could skew the data.

Pre and post employee surveys were a crucial tool to appraise the development of this QI initiative and commenced April 2016 with a follow-up assessment in July 2016. The survey utilized was developed by Catherine Tantau of Catherine Tantau & Associates (Appendix B), a renowned healthcare consulting firm focused on improving patient access to care and efficiency (Tantau & Associates, 2009). The tool was identified on the Institute for Healthcare Improvement (IHI) website, where it is published and is accessible for use. In a personal

communication with Ms. Tantau (personal communication March 14, 2016), permission for use was granted and further confirmed through e-mail communication (Appendix C).

The survey uses a 10-point rating scale that offers a range of responses for six separate questions focusing on teamwork, cooperation, attitudes, and level of respect in the work environment. In addition, the survey provides a comment section for further statements or reflections. The health department utilizes Survey Monkey® for distribution of e-mail surveys, which was the method employed and further eased access to e-mail accounts for dissemination of pre and post evaluation. The Outreach Team that creates surveys for the health department participated in the process and collected results. The selection of method ensured protection of employee privacy and anonymity, which further encouraged participation.

The combined provider and employee satisfaction survey that was employed for this project was created to measure progress in the implementation of the Advanced Access Model for patient-centered care (Tantau 2009). As the current project setting was seeking PCMH accreditation and FQHC funding, this was an appropriate tool. The foundation for this model is reducing cost and delays associated with the provision of patient care in a primary care setting. Costs and delays are barriers that may translate to alterations in patient, provider, and employee satisfaction (Tantau, 2009). Evaluation of these elements during this transition had value, not only for this project, but in fulfilling the health department vision of being viewed by the county as a primary resource for individuals and community health (Wilkes, 2006).

Employee satisfaction is critical to organizational success. The retention of qualified, empathetic, and passionate employees was anticipated to demonstrate success in the transformation of organizational culture. A retrospective evaluation of staff retention for eight

months preceding this quality improvement initiative was examined. These data were utilized for a comparative analysis following closure of this project.

### **IRB Process and Approval**

This is a scholarly project for a Doctorate of Nursing Practice Program. The project site deemed Institutional Review Board (IRB) approval was unnecessary and organizational approval was granted (Appendix D). All data and tools previously discussed were submitted to e-Pirate, the University Medical Center Institutional Review Board (UMCIRB) utilized by East Carolina University, College of Nursing. This was then reviewed by the project committee and the Office for Research Integrity and Compliance (ORIC). As it was deemed the project was outside UMCIRB jurisdiction and federal descriptions for human subjects were not a component of this quality improvement initiative, exemption from IRB approval was granted. Permission to proceed with project implementation was authorized.

## Chapter 4

### Results

The pre-evaluation employee and provider satisfaction survey was launched April 2016. Twenty-nine surveys were distributed to the clinic, provider, supporting staff, and leadership staff with a 76% response rate. The tool was a Likert-type scale that allowed a range of responses with one being the least and 10 being the highest rating. This type of scoring was beneficial in offering approximate percentages when analyzing employee satisfaction. In evaluating the health department as a place to work, the initial results indicated generally poor satisfaction scores in all domains. In rating the team as a place to work, the weighted average was 6.95 on a 10-point scale. Many of the other survey questions revealed similar ratings: Level of courtesy and respect by medical and non-medical staff received an average rating of 6.86; cooperation, communication, willingness to assist each other rated 6.73; recommending your workplace for loved ones to come for care rated 6.59; and personal morale weighted at 6.86.

The lowest score was at 5.32 for rating the morale of other coworkers in this health department setting. Notably, 13 of the 22 respondents rated levels at six or below for the perception of morale for their fellow teammates. There was a clear contradiction between perceived levels of personal and coworker morale in this work environment. In statistical terms, 59% of the clinic, accounts receivable, and registration staff would score fellow team members at or below 60% for demonstration of behaviors for employee morale. The average level of perceived morale for coworkers was rated at 30% below personal morale. A perception that coworkers have limited enjoyment of their work activities has strong potential to negatively influence job enjoyment. As Anzai, Douglas and Bonner (2014) indicated, a positive and amicable work climate have a strong correlation to employee morale.

While the weighted averages for the initial survey were telling, those that provided reflective comments were more enlightening. Of the 22 respondents, eight elected to provide additional statements. A negative coworker attitude was cited as contagious and affecting. Ineffective group communication, lack of cooperation, and petty behaviors were listed as concerns by another respondent. This respondent stated: “I really enjoy working with my immediate group of coworkers, once outside of that group, cooperation and communication is lacking.” Another respondent commented: “Inside of my own area of work, all the the above answers would approach 9-10. Step outside of my area of work and the numbers plummet.” Perceived lack of management support with favoritism with unequal treatment was shared by three individuals. Statements included: “Employee favoritism occurs in our workplace;” “supervisors, you go to them to try to fix things and then they fire back at you making things worse and make our work environment feel stressful.” One staff member cited concerns for feeling unappreciated and approaching “burn out.” This employee reported “I don’t feel appreciated for what I do, in the amount of effort, love, and care that I put into my job.” Subtle expressions perceived for a lack of ability to fulfill the job roles were highlighted apprehensions for job satisfaction. The need to treat others with tolerance and forcing new staff members to “prove themselves” were also shared concerns. There were some positive comments in terms of recent improvements and desiring to remain in this work environment. Only one respondent had all positive statements and demonstrated the highest ratings among all the survey results.

The post evaluation survey was launched 3 months after the initiation of this QI initiative in July 2016. Participants were asked to share thoughts or concerns, recent improvements that were experienced or witnessed, and further identify areas requiring additional enhancement.

Requesting these particular comments and reflections created opportunity for the continuation of this organizational improvement beyond the realm of this project.

Dialogue regarding *FISH!* culture became a commonplace behavior. “I’m fishing;” “I’m learning to swim;” “go fish;” “are you fishing today;” and in instances of distress, “let’s try to be fishy about this” are examples of how this became ingrained into the daily work culture. It became the way we reminded each other of our facility mission and goals, and our individual and unified desire to enjoy our work culture. In addition to these were statements regarding each of the four key cornerstones of the *FISH!* Philosophy. Team members that did not exhibit the expected behaviors were reminded through “fish” wording to choose their attitude, play, make their day, and be there. The weekly team building activities created opportunities to introduce, discuss, and solidify the purpose of improvements in the work climate.

The poster contest was a remarkable success. While there were members of each group that did not fully participate, the majority of team members engaged in the creation of a poster that represented their assigned concept of the *FISH!* Philosophy. This assignment triggered friendly competition and instituted interdepartmental discussion among team members about the *FISH!* culture. The presentations from each group were emotionally charged, thoughtful in the development, and fun in the delivery. They accurately targeted the key concepts of the *FISH!* culture. A repeat of this was instituted facility wide as the overall aim was to adopt this philosophy as the work culture for the entirety of the health department. The “Be There” poster now resides in the office of the health director as she is an advocate of this concept. The “Make Their Day” poster is present in the clinic hallway. It includes little buckets that house sweet treats and sticker rewards for staff and patients.

Human behavior is difficult to measure. Independent observation and ongoing dialogue related to comments about “fish” supported improvement and some level of success. There was a perceived shift in the energy level and overall employee satisfaction that is challenging to quantify in a brief survey and QI project. Progress and achievement were also determined as advantageous through team members that may have demonstrated limited participation, but did not actively resist the cultural change initiatives. As stated previously, the desire for group conformity has a powerful influence on employee behaviors and organizational culture (Shirey, 2013). The shift to evoke positive team member attitudes became more apparent throughout the project progression. There were several team members that consistently demonstrated *FISH!* culture and language. Their active engagement was strongly influential.

Twenty-nine surveys were redistributed, with 19 responses. A lower response rate than expected could be attributed to leaves of absence due to surgery, maternity, and an extended familial visit out of the country. Of those that responded to the post-satisfaction survey, 10 respondents provided additional comments, which was a decreased response rate. Their final anonymous responses were authentic and offered both encouragement and areas requiring further improvement. For those that shared concerns or areas requiring additional enhancement, three comments targeted additional areas of interest. One staff member criticized the component of Play in the *FISH!* Philosophy concept with the statement: “Not all areas have the luxury of being able to “play” when they do not have patients – some areas still have work to be completed in a timely manner.” The concept of “play” was previously identified as a potential for the lack of utilization in healthcare delivery as a lighthearted approach may be perceived as unfavorable in the healthcare realm. Employee favoritism remained a concern with one respondent expressing additional statements of the looming burden of seeking FQHC grant funding and job security.



The only other negative response was related to interdepartmental morale and lack of communication.

The remaining responses to the post-satisfaction survey were all positive. They included: “We’re fishing;” “overall, I think it’s a great place to work;” “I noticed a big improvement in the dynamics at work;” “it’s good when we can all get together and have fun and put work aside briefly;” and “I think this project may have helped some.” While there was an advancement in employee morale through this QI initiative, the most notable changes proved difficult to accurately measure and were secured through informal examination, observation, and interdepartmental staff interactions.

Six different domains of the work climate were analyzed through the combined employee and provider satisfaction survey. There were improvements noted in each component following this QI initiative (see Table 2). Although independent observation, comments provided on the post satisfaction survey, and employee participation in “fish themed” events demonstrated an overall improvement in staff perceptions of an improvement in the work culture within this rural health department, this QI initiative will continue. The most notable enhancements were identified in three areas. In rating the team as a place to work there was a 10% increase in job satisfaction, rating the health department as a place you would recommend for loved ones increased by 11%, and the most notable increase in scoring was for the morale of coworkers that increased by 12%. There were also gains noted in personal morale with a 6% improvement. The areas that had gained almost no growth were related to interdepartmental cooperation, communication, and levels of courtesy and respect.

## Pre and Post Survey Results for the Provider and Employee Satisfaction Survey

Table 2

### *Survey Results for a Six Question 10-point scale*

<u>Question of interest</u>	<u>Pre- evaluation</u>	<u>Post- evaluation</u>	<u>% Change</u>
How would you rate your team as a place to work?	6.95	7.63	10%
How would you rate the level of courtesy and respect with which you are treated by people at all levels, including medical and non-medical staff?	6.86	7.05	3%
How would you rate how well people you work with cooperate, communicate and help each other out?	6.73	6.89	2%
How would you rate other people's attitudes about working here, in other words, their morale?	5.32	6.00	12%
How would you rate your own attitude about working here, in other words, your morale?	6.86	7.26	6%
Would you recommend your team as a place for your loved ones to come for care?	6.59	7.32	11%

*Note.* Increases were noted in all domains assessed.

\*There was a lower post response rate due to extended leaves of absence

## Patient Satisfaction

Patient satisfaction surveys are analyzed quarterly by the Community Outreach Team. A mere 10 surveys were completed by patients utilizing the clinic services for the entire reporting year of 2015. Thirty-six survey results were completed during the April to June quarter, which demonstrated the team member effort to distribute patient satisfaction survey cards. The analysis of these data was generally encouraging. Of the survey respondents, eight were in the Spanish version and 28 were in the English version. The results for the Spanish-speaking respondents were lower on average than English. Ratings for the clinical experience approached 90%, with the lowest rating at 75% for recommending the clinic to others. Conversely, the English-speaking respondents rated the clinic with exceptionally high scores, at 100% ratings in most

categories. The lowest rating was related to hours of operation to meet healthcare needs, which was rated at 93% (see Table 3). Additionally, the provision of comments was promising as there were no negative statements. They included: “Wouldn’t change anything”; “amazing staff and care”; “all of you do a great job”; “everyone is always so nice and helpful here”; and “friendly and neat office.”

Table 3				
<i>Patient Satisfaction Survey</i>				
<u>Help Us Help You!</u>	<u>English-speaking (yes)</u>	<u>English-speaking (no)</u>	<u>Spanish-speaking (yes)</u>	<u>Spanish-speaking (no)</u>
Were our staff members courteous and polite?	100% (28)	–	88% (7)	12% (1)
Were our staff members neat in appearance?	100% (28)	–	100% (8)	–
Were you seen at your appointment time?	96% (27)	4% (1)	86% (6)	14% (1)
If not, were you told why?		100% (1)	13% (1)	13% (1)
Did our staff spend enough time with you?	100% (28)	–	100% (7)	–
Did our staff speak to you in words that you understood?	100% (28)	–	88% (7)	12% (1)
Did the services provided by our staff adequately your needs & expectations?	100% (28)	–	88% (7)	12% (1)
Would you recommend or tell other people to use our services?	100% (28)	–	75% (6)	12% (1)
Do our hours of operation meet your needs?	93% (26)	7% (2)	88% (7)	12% (1)
<i>Note.</i> Spanish-speaking respondents did not answer all posed questions.				

The survey results were compared to the previous two reporting years. Data was compared to the same quarter where the project was implemented and year-end results. There are conflicting conclusions (see Table 4). It should be noted that a 20% increase was achieved in a survey distribution in a single quarter compared to year-end results. Marginal increases were



## Chapter 5

### Discussion

In a healthcare industry increasingly focused on patient satisfaction, transforming a floundering culture is the key to unlocking success. As Donohue (2012) discussed, few Americans work in an environment that provides support, recognition, and invokes passion for daily work. Analysis of available literature indicated that public health settings are particularly vulnerable to attrition and often lack the organizational support or job satisfaction levels that encourage retention of qualified team members (Liss-Levinson et al., 2015). Creating an organizational culture that celebrates diversity, motivates team members, and enhances job satisfaction was the aim for this QI initiative. The translation was an anticipated improvement in employee morale, employee retention, and patient satisfaction.

The *FISH!* Philosophy was utilized as the framework for organizational improvement within a rural public health department setting. A thorough literature review yielded no results for the application of this philosophy in a primary care setting. Despite this, the cornerstones of *FISH!* are world renowned with successful application and sustainability in numerous settings including acute healthcare environments. Lewin's Change Theory was the assistive mechanism to guide staff members through the process of change and was useful in anticipating resistant members of the healthcare team.

The tool utilized to measure combined provider and staff satisfaction was developed by Catherine Tantau of a renowned consulting firm focused on improving access to care and efficiency in a primary care setting. The 10-point Likert-type scale allowed for average

percentage scoring. Evaluations prior to the initiation of this QI project indicated generally poor satisfaction scores in all of the six domains assessed. The component that highlighted the lowest ratings was related to perceptions of morale for fellow co-workers. Average scoring revealed ratings of team member morale at 30% lower than personal morale. This demonstrated that 59% of the clinic, accounts receivable, and registration staff rated team members at or below 60% for demonstration of behaviors of employee morale. If this were an academic grade, they would have received a “D” for their performance. This influence has a strong potential to negatively impact employee satisfaction and the work enjoyment (Anzai, Douglas, Bonner, 2014).

At the closure of this QI initiative, improvements were gained in all realms assessed. A remarkable advancement was a 10% increase in overall employee satisfaction with the work environment in three months. The greatest improvement was the ratings for co-worker levels of morale. These were notably low prior to the project initiation. A 12% increase in rating the morale of other coworkers could potentially be translated to an overall improvement in organizational enhancement.

The tool utilized to measure patient satisfaction was underutilized, with only 10 surveys completed in the 2015 reporting year with an average year-end score of 78% among English-speaking respondents. A low response rate could have skewed the data and resulted in the low satisfaction scores. Comparison to previous reporting years reveal conflicting results and fluctuating levels of satisfaction, especially among Spanish-speaking respondents. Thirty-eight surveys were completed in 2014 and 10 surveys in all of 2015. This demonstrated the of a lack of concerted effort to examine employee performance and patient satisfaction prior to this QI initiative. In order to appropriately assess patient satisfaction, it was deemed necessary to actively distribute the current tool. Thirty-six were submitted during the quarter for this QI

project revealing a 20% increase in a single quarter compared to previous year-end results.

Improvements are noted among English-speaking respondents and decreases among the Spanish population. Since this was not actively assessed in the two years prior to this QI initiative, accurate comparison is difficult.

The current tool has been in use for nine years and may not be the best measure of patient satisfaction. An amended survey or selection of a validated tool would make comparison challenging but enhance evaluation of performance. In addition to considerations for an update, the QI team is advocating for tablet utilization at the time of check-out for survey completion. This would enhance the capture of survey completion and reduce the possibility of skewed data due to limited response rates. In an organization that is targeting a 90% patient and employee satisfaction rate for FQHC funding, accurate measurement is essential.

The aim of this project was to institute a framework for improvement in the organizational culture of a difficult and challenging work environment in a public health setting. While the post satisfaction survey results do not completely portray the change, informal assessment, employee comments, and strong patient satisfaction scores validate a successful QI initiative. A shift in the organizational culture within the patient care areas occurred.

Cultural change may be one of the most challenging endeavors in healthcare. Altering the methods in how staff approach their daily work, interact in new processes, perceive their job roles, and the implications of their functions is challenging. In a public health setting, where there is a perception that the job is guaranteed, there appears to be lack of recognition that the facility must be financially viable. Although this health department is supported through local, state, and federal funding, the Joint Commission Accreditation, the Duke Endowment Grant, and FQHC funding are essential for long-term financial sustainability.

## **Sustaining Change**

While implementing change is challenging, sustainability may be even more difficult. It is anticipated that the principles of the *FISH!* Philosophy will become part of orientation and training. The health director has confirmed this desire and voiced the same intent. She has also expressed an expectation that the cornerstones of this philosophy will become the ingrained culture for the entirety of this public health department. This was a previous mission; however, marked staff turnover forced abandonment of this goal. A consultant has been secured to assist in this process for the health department. No cost will be incurred as the individual is contributing her services to public health. Change in the culture of healthcare delivery can only be maintained when employees recognize personal benefit. Regular reinforcement through management support staff, practitioners, and the medical director are necessary to achieve this mission. Ongoing efforts through initial orientation, regular shift huddles, monthly meetings, and special events will be necessary to sustain this QI initiative.

The current social committee is anticipated to adopt many of the team building exercises that were incorporated through this QI project. As the project investigator, joining this group in addition to the QI team will continue the momentum. This project was the springboard for an introduction to an organizational cultural change initiative within this public health department. Co-participation from leadership staff that includes the health director, medical director, practitioners, and departmental leads will be necessary to sustain change and continue the future ambitions for a system-wide improvement initiative. The anticipated translation is improved patient interactions and enhanced healthcare delivery. This is especially imperative for



achievement and maintenance of Joint Commission accreditation, PCMH accreditation and FQHC funding. Additionally, this health department must be able to continue to secure Duke Endowment grant funding to remain sustainable.

### **Limitations**

Cultural improvement is a long and arduous process. The major limitation for this QI initiative was the timeframe allotted for implementation. Three months for project achievement limited the aims of this QI initiative. Although there was a clear improvement noted between the pre and post provider and employee satisfaction surveys and in independent observation, organizational change is a process. Another limitation was noted in the lack of literature available for implementation of the *FISH!* Philosophy in primary care or public that might serve as a guide for this QI initiative. While there is clear sustainability in the literature within an acute care setting, there were constraints for utilization or implementation of the *FISH!* Philosophy in a primary care or public health settings as a model for a successful and sustainable organizational change within the setting of this QI initiative. Additionally, a thorough literature review yielded no current information related to quantitative values of self-rated levels of employee morale in the primary care or public health setting.

## References

- Anazi, E., Douglas, C., Bonner, A., (2014). Nursing practice environment, quality of care, and morale of hospital nurses in Japan. *Nursing and Health Sciences* (16), 171-178.
- Brazil, K., Wakefield, D. B., Cloutier, M. M., Tennen, H., Hall, C. B. (2010). Organizational culture predicts job satisfaction and perceived clinical effectiveness in pediatric primary care practices. *Health Care Management Review*. 35(4), 365-371. doi: 10.1097/HMR.0b013e3181edd957
- Butts, J. B. & Rich, K. L. (Eds.). (2015). *Philosophies and theories for advanced nursing practice* (2<sup>nd</sup> ed). Burlington, MA: Jones & Bartlett Learning.
- Centers for Medicare and Medicaid Services [CMS]. (2016). *Medicare benefit policy manual*. Retrieved from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>
- Deckelman, S., Kubat, M. A., Lenkay, J., Nims, L., Schriener, C., & Sullivan, D. (2010). Collaboration of nursing faculty and college administration in creating organizational change. *Nursing Education Perspectives*, 31(6), 381+. Retrieved from <http://go.galegroup.com.jproxy.lib.ecu.edu/ps/i.do?id=GALE%7CA245167141&v=2.1&u=gree96177&it=r&p=HRCA&sw=w&asid=e74cb0dac9613005ed10768299c4cfae>
- Donohue, M. A., (2012). What can you do when work isn't working? *Nursing Management*, 43(6), 49-51. doi: 10.1097/01.NUMA.0000414862.31384.fb
- Dugan, D. P., Mick, S. S., Scholle, S. H., Steidle, E. F., Goldberg, D. G., (2011). The relationship between organizational culture and practice systems in primary care. *Journal of Ambulatory Care Management*, 34(1), 47-56. doi: 10.1097/JAC.0b013e3181ff6ef2

- Harper, E., Castrucci, B. C., Bharthapudi, K., Sellers, K., (2015). Job satisfaction: A critical, understudied facet of workforce development in public health. *Journal of Public Health Management and Practice*. 21(6), 46-55. doi: 10.1097/PHH.0000000000000296
- Hicks, J. M., (2011). Leader communication and organizational health. *Health Care Management*, 30(1), 86-91. doi: 10.1097/HCM.0b013e3182078bf8
- Liss-Levinson, R., Bharthapudi, K., Leider, J. P., Sellers, K., (2015). Loving and leaving public health: Predictors of intentions to quit among state health agency workers. *Journal of Public Health Management and Practice*. 21(6), 91-101. doi: 10.1097/PHH.0000000000000317
- Lundin, S. C., Paul, H., & Christensen, J. (2000). *Fish! A remarkable way to boost morale and improve results* [Kindle version]. Retrieved from <https://read.amazon.com/>
- Lyall, J. (2007). Something fishy. *Nursing Management*, 13(10), 8-11. Retrieved from <http://search.proquest.com.jproxy.lib.ecu.edu/docview/236927438?accountid=10639>
- Oreg, S., & Sverdlik, N. (2011). Ambivalence toward imposed change: The conflict between dispositional resistance to change and the orientation toward the change agent. *Journal of Applied Psychology*, 96(2), 337-349. doi:10.1037/a0021100
- Peluchette, J., Karl, K. A., (2005). Attitudes toward incorporating fun into the health care workplace. *E-Journal of The Healthcare Manager*, 24(3), 268-275. Retrieved from [http://ovidsp.tx.ovid.com.jproxy.lib.ecu.edu/sp-3.17.0a/ovidweb.cgi?&S=BEJHFPKNLDDFNHLNCJKOCGCOKMBAA00&Link+S+t=S.sh.21|1|sl\\_10](http://ovidsp.tx.ovid.com.jproxy.lib.ecu.edu/sp-3.17.0a/ovidweb.cgi?&S=BEJHFPKNLDDFNHLNCJKOCGCOKMBAA00&Link+S+t=S.sh.21|1|sl_10)
- Rees, T., (2004). Hospital hooks FISH! Philosophy. Treatment, visits at Silver Cross become more pleasant experiences. *Profiles for Healthcare*, 20(2), 18-22

Roth, L. M. & Markova, T. (2012). Essentials for great teams: Trust, diversity, communication and joy. *Journal of the American Board of Family Medicine*, 25(2), 146-148. doi: 10.3122/jabfm.2012.02.110330

Searching for a model of excellence. (2015). In *FISH!* Retrieved from <http://www.fishphilosophy.com/>

Shirey, M. R. (2013). Lewin's theory of planned change as a strategic resource. *Journal of Nursing Administration*, 43(2), 69-72. doi: 10.1097/NNA.0b013e31827f20a9

Tantau, (2008). Accessing patient-centered care using the advanced access model. *Journal of Ambulatory Care Management*, (32)1, 32-43. doi 10.1097/01

Tantau & Associates. (2009). Tantau & Associates designs Advanced Access systems that are patient focused and provider friendly while improving service and reducing costs.

Retrieved from <http://www.tantauassociates.com/>

Tong, J. & Wang, L. (2011). Work locus of control and its relationship to stress perception, related affections, attitudes and behaviours from a domain-specific perspective. *Stress and Health*, (28), 202-210. doi 10. 1002/smi.1423

Tsai, Y. (2011). Relationship between organizational culture, leadership behavior and job satisfaction. *BMC Health Services Research*, 11(5). doi: 10.1186/1472-6963-11-98

White, K., & Whitman, P. (2008). Caught the "big one": How a newly integrated home health billing department, working with a coach, use the FISH philosophy to catch team spirit. *An Interdisciplinary Focus to Home Healthcare Management & Practice*, 18(4), 300-305. doi: 10.1177/1084822305284748

Wilkes County Health Department, (2006). About us: Vision. Retrieved from <http://wilkeshealth.com/about-us/>

## Appendix A

**Clinic/Outreach/Diabetes/MESH/WIC Survey**  
**Circle area seen in today**  
**Please complete and drop in the mail – THANKS!**

**Help Us Help You!**

- |                                                                                      | <b>Yes</b>               | <b>No</b>                |
|--------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Were our staff members courteous and polite?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Were our staff members neat in appearance?                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Were you seen at your appointment time?                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| If not, were you told why?                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Did our staff spend enough time with you?                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did our staff speak to you in words that you understood?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Did the services provided by our staff adequately meet your needs & expectations? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Would you recommend or tell other people to use our services?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do our hours of operation meet your needs?                                        | <input type="checkbox"/> | <input type="checkbox"/> |

What changes would you suggest we make to improve our services? \_\_\_\_\_

Other comments: \_\_\_\_\_

Signature (optional) \_\_\_\_\_

## Appendix B

## Tantau &amp; Associates

PO Box 179 Chicago Park, CA 95712 530-273-6550  
[ctantau@gv.net](mailto:ctantau@gv.net)

## PROVIDER AND STAFF SATISFACTION SURVEY

Please respond to the following questions using a scale of 1 to 10 (with 1 being lowest rating and 10 the highest rating).

1. How would you rate your team as a place to work on a scale of 1–10?

1   2   3   4   5   6   7   8   9   10

2. How would you rate the level of courtesy and respect with which you are treated by people at all levels, including medical and non-medical staff?

1   2   3   4   5   6   7   8   9   10

3. How would you rate how well people you work with cooperate, communicate and help each other out?

1   2   3   4   5   6   7   8   9   10

4. How would you rate other people's attitudes about working here, in other words, their morale?

1   2   3   4   5   6   7   8   9   10

5. How would you rate your own attitude about working here, in other words, your morale?

1    2    3    4    5    6    7    8    9    10

6.    Would you recommend your team as a place for your loved ones to come for care? (1 = would not recommend...10 = highly recommend)

1    2    3    4    5    6    7    8    9    10

Comments:

## Appendix C

**From:** Catherine Tantau [mailto:ct@tantauassociates.com]  
**Sent:** Monday, March 07, 2016 4:24 PM  
**To:** Walsh, Leslie <lwalsh@wilkescounty.net>  
**Cc:** 'Catherine Tantau' <ct@tantauassociates.com>  
**Subject:** RE: Provider and Staff Satisfaction Survey

Ms. Walsh,

It was a pleasure speaking with you today. I do not have information regarding the validity and reliability of this tool. It was designed specifically to track changes in staff satisfaction throughout a process improvement program for Advanced Access in the medical office setting.

I hope this is helpful and wish you every success in your work.  
Kind regards,  
Catherine

***Catherine Tantau***  
**President, Tantau & Associates**  
[ct@tantauassociates.com](mailto:ct@tantauassociates.com)  
**POB 179, Chicago Park, Calif 95712**  
**530-273-6550**

---





## Appendix D



### WILKES COUNTY HEALTH DEPARTMENT

Promoting health and preventing disease in our community

November 10, 2015

To Whom It May Concern

We at the Wilkes County Health Department have reviewed Ms. Leslie Walsh's DNP Scholarly Project: "Implementation of the FISH! Philosophy in Primary Care: A change in the culture of healthcare delivery". Ms. Walsh has organizational support and approval to conduct her project within our health department clinics. We understand that for Ms. Walsh to achieve completion of the DNP program, a public presentation and manuscript submission related to the scholarly project will be required by the University.

Our organization has deemed this project as an improvement initiative and does not require institutional IRB review.

Thank you,

A handwritten signature in black ink that reads "Ann Absher".

Ann Absher, RN, MPH  
Health Director




## Appendix E

**EAST CAROLINA UNIVERSITY**

Office of Research Integrity and Compliance (ORIC)  
University & Medical Center Institutional Review Board (UMCIRB)  
Brody Medical Sciences Building, 4N-70 • 600 Moye Boulevard • Greenville, NC 27834  
Office 252-744-2914 • Fax 252-744-2284 • [www.ecu.edu/irb](http://www.ecu.edu/irb)

---

TO: Leslie Walsh, ECU College of Nursing, DNP Program

FROM: Office for Research Integrity & Compliance (ORIC) 

DATE: March 2, 2016

RE: DNP Project

TITLE: Implementation of the *FISH!* Philosophy in Primary Care: A change in the culture of healthcare delivery

This activity has undergone review on 3/2/2016 by the ORIC. A Doctor of Nursing Practice candidate is planning a process improvement initiative to improve the quality of patient care and employee satisfaction at the Wilkes County Health Department. The goal is to improve staff retention and fulfillment along with patient satisfaction by enhancing the conduct of daily work.

This activity is deemed outside of UMCIRB jurisdiction because it does not meet the current federal descriptions for human subject research. Therefore, this activity does not require UMCIRB approval. Contact the office if there are any changes to the activity that may require additional UMCIRB review or before conducting any human research activities

Relevant Definitions for Human Subject Research:

- *Research* means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities
- *Human subject* means a living individual about whom an investigator (whether professional or student) conducting research obtains:
  - (1) Data through intervention or interaction with the individual, or
  - (2) Identifiable private information.

**The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.**

## Arledge Scholarly Practicum Timeline

